Figure 2-20-N-4 Information Management Functional Requirements (Continued)

2.5.16 The CEIS shall report the actual TRICARE Senior enrollment versus enrollment capacity for the demonstration sites by MTF.

2.5.17 The CEIS shall report inpatient and outpatient utilization and cost for TRICARE Senior Prime enrollees and shall compare the data to other peer and normative data.

2.5.18 The CEIS shall report the cost of all space-available care provided to non-enrolled Medicare eligible beneficiaries compared to level of effort.

2.5.19 The CEIS shall report the count and cost of ancillary services (laboratory, radiology, and pharmacy) provided to TRICARE Senior Prime enrollees.

2.5.20 The CEIS shall report the count and cost incurred by TRICARE Senior Prime enrollees seen outside the enrollment MTF.

2.5.21 The CEIS shall report preventive service delivery rates for TRICARE Senior Prime enrollees.

2.5.22 The CEIS shall report the count and cost of community-based care (hospice, skilled nursing facility, home health care) provided to TRICARE Senior Prime enrollees.

2.5.23 The CEIS shall compare monthly cost and utilization information for TRICARE Senior Prime enrollees to TRICARE Senior Prime key performance targets.

2.5.24 The CEIS shall report TRICARE Senior Prime performance and receipt of interim payments on a national, site and MTF level.

2.5.25 The CEIS shall report the total number and percentage of TRICARE Senior Prime enrollees with OHI.

2.5.26 The CEIS shall report the number of TRICARE Senior Prime patient visits to their PCM and other providers.

2.5.27 The CEIS shall report the disenrollment by the length of time the beneficiary was in the plan, and indicate the reason for disenrollment.

2.5.28 The CEIS shall report the re-enrollment rates, by the length of time the beneficiary was out of the plan.

2.5.29 The CEIS shall report the total number and rate of TRICARE Senior Prime enrollees requesting a change of PCM and indicate the reason for the change.

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

2.5.30 The CEIS shall provide an updated EBC Scorecard that reports separately for TRICARE Senior Prime enrollees and Medicare eligible non-enrollees using the EBC costing methodology.

2.5.31 The CEIS shall report the projected and actual interim payments from HCFA on a national and site level.

2.5.32 The CEIS shall report a monthly and annual reconciliation based on projected and actual interim payments. All calculations will be based on the Medicare site and MTF projected historical level of effort (LOE) and enrollment.

2.5.33 The CEIS shall report the actual MTF and site enrollee expenses priced per the PLCA methodology, for both incremental and full costs, projected for the annual reconciliation by site and DoD.

2.6 MPC

The MPC will provide the system for all electronic communications to HCFA for enrollment and "claims" reporting. The MCSCs shall use the MPC system to enter enrollment data for HCFA, in addition to CHCS MCP to enter complete TRICARE Senior enrollments to DEERS. The MPC simplifies communications and improves data quality for all demonstration participants. Under current proposed enrollment data flow processes, the MPC will gather data from MHS systems, e.g., MCSC, DEERS, and CEIS, perform data manipulations as necessary, and provide a single transmission to the HCFA. The MPC system will transmit Medicare data to the MCSCs, DEERS, and CEIS. The MPC will also reconcile enrollment and encounter data to ensure that the HCFA and DEERS are synchronized.

Enrollment Data Requirements:

2.6.1 The MPC shall provide required enrollment information to the HCFA for TRICARE Senior Prime.

2.6.2 The MPC shall receive enrollment information from the HCFA for reconciliation. This will include a monthly enrollment, disenrollment, and error report, a transaction and activity report, and a membership report.

2.6.3 The MPC shall verify TRICARE Senior Prime enrollment eligibility online via DEERS.

2.6.4 The MPC shall process and maintain TRICARE Senior Prime enrollments, disenrollment, and beneficiary information.

2.6.5 The MPC shall report HCFA enrollments, disenrollment, updates, and errors to the MCSC.

2.6.6 The MPC shall send an enrollment reconciliation report to the MCSC.

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

2.6.7 The MPC shall establish a waiting list of eligible applicants for TRICARE Senior Prime.

2.6.8 The MPC shall verify Medicare eligibility against an eligibility file provided by HCFA.

2.6.9 The MPC shall receive monthly eligibility files from DEERS.

2.6.10 The MPC shall receive a monthly TRICARE Senior Prime enrollment file from DEERS.

2.6.11 The MPC shall receive a monthly TRICARE Prime enrollment file from DEERS, which will be used to predict age-in eligibility.

Claims Data Requirements:

2.6.12 The MPC shall receive civilian encounter data in HCFA 1500 and UB 92 format from the MCSCs.

2.6.13 The MPC shall receive direct care encounter data in HCFA 1500 and UB 92 format from the CEIS.

2.6.14 The MPC shall transmit claims data as required by the HCFA.

2.6.15 The MPC shall accept claim error information from the HCFA and send claim error info back to the MCSC and CEIS.

Report Requirements:

2.6.16 The MPC shall provide a monthly enrollment capacity report to the MCSCs indicating the current enrollment and number of available enrollment spaces.

2.6.17 The MPC shall provide monthly enrollment processing activity and error report to the MCSCs.

2.6.18 The MPC shall provide a reconciliation report to the MCSCs.

2.6.19 The MPC shall report TRICARE Senior waiting list information by demonstration MTF to the MCSCs and CEIS.

2.6.20 The MPC shall provide a report to the MCSCs indicating the number of applications entered per day.

2.6.21 The MPC shall provide a daily list to the MCSCs of applications entered or received per day.

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

2.6.22 The MPC shall provide a report to the MCSCs indicating applications with no telephone attempts in the first 10 days.

2.6.23 The MPC shall provide a report to the MCSCs of applications inactive for 35 days.

2.6.24 The MPC shall provide a monthly enrollment activity and error report to MCSCs resulting from HCFA processing.

2.6.25 The MPC shall provide the MCSCs a pre-edit error report of enrollment activity awaiting transmission to HCFA.

2.6.26 The MPC shall provide the MCSCs a report of HCFA-accepted enrollments to include all discrepancies between DEERS and the application information entered into MPC.

2.6.27 The MPC shall provide the MCSCs a monthly enrollment reconciliation report specifying the discrepancies between DEERS and HCFA enrollment information.

2.6.28 The MPC shall provide a monthly enrollment capacity report to the MCSCs indicating the number of available spaces and the wait list applicants for those enrollment slots.

2.6.29 The MPC shall provide the MCSCs a monthly report of TRICARE Senior Prime Enrollees which specifies the discrepancies between DEERS and MPC zip code.

2.6.30 The MPC shall provide the MCSCs a monthly report of MCSC-submitted disenrollments by disenrollment reason.

2.6.31 The MPC shall provide the MCSCs a report of TRICARE Prime enrollees eligible to age-in to TRICARE Senior Prime per DEERS. Age-in letter and labels can also be provided.

2.6.32 The MPC shall provide annual working aged confirmation to the MCSCs with enrollee information pre-printed for mailing.

2.6.33 The MPC shall provide the MCSCs a report of enrollees who have not returned the working aged confirmations.

2.6.34 The MPC shall provide an application/enrollment file available for downloading by the MTFs.

2.7 TMA, AM&S

The TMA, AM&S office will receive and process the HCSR data from the MCSC. Encounter data is received and processed daily by TMA, AM&S, and then transmitted to the CEIS.

Enrollment Data Requirements:

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

There are no enrollment data requirements for the TMA, AM&S. (Enrollment DMIS ID shall be provided on the HCSR by the MCSC)

Claims Data Requirements:

2.7.1 The TMA, AM&S shall accept the HCSR data from the MCSCs as specified in the overall contract.

2.7.2 The TMA, AM&S shall send the HCSR and EBC data to the CBIS on a monthly basis.

Report Requirements:

There are no report requirements for TMA, AM&S.

3. INTERFACE IDENTIFICATION

The requirements below define the new interfaces required for the TRICARE Senior Prime demonstration. This section does not define the technical and communication components of the interfaces among the systems. Exhibit 1 provides a graphical representation of the TRICARE Senior Prime system interfaces for the enrollment data flow process. Exhibit 2 provides a graphical representation of the system interfaces for the claims/clinical data flow process for the TRICARE Senior Prime demonstration project.

3.1 New Enrollment Interfaces Required for TRICARE Senior Prime

3.1.1 The MCSCs shall interface with the MPC for Medicare enrollment information and updates.

3.1.2 The MPC shall interface with the DEERS for MHS/Medicare eligibility and enrollment.

3.1.3 The MPC shall interface with HCFA for Medicare enrollment processing.

3.1.4 The MPC shall interface with the CBIS for Medicare eligibility and entitlement for Senior Prime enrollees.

3.2 New Claims Interfaces:

3.2.1 The MCSCs shall interface with the MPC to transmit UB 92 and HCFA 1500 records.

3.2.2 The CBIS shall interface with the MPC to transmit HCFA 1500 and UB 92 records as mutually agreed upon by DoD and HCFA.

3.2.3 The MPC shall interface with the HCFA for required encounter data.

Figure 2-20-N-4 Information Management Functional Requirements (Continued)

4.5.1 The Contractor shall implement network security measures to prevent unauthorized access via the Internet/DISN WAN and to obtain certification and accreditation of the Contractor furnished network at the C2 level of trust.

4.5.2 The Contractor shall implement security measures to protect the system and data resources, procedures to react to computer emergency response team (CERT) security notices, and procedures designed to detect and correct security vulnerabilities.

4.6 The Contractor shall comply with the requirement to obtain the minimum personnel security investigations as prescribed by DoDD 5200.2-R based on the individual's responsibilities and access to sensitive, unclassified or confidential information.

4.7 All contractor personnel who have access to SBU or confidential medical information shall be designated as ADP-I, ADP-II, or ADP-III as defined in DoDD 5200.2-R. Once personnel are classified, the appropriate investigation forms, finger print cards, and questionnaires shall be completed and submitted to the assigned Government AIS Security Officer for processing.

4.8 The Government may authorize contractor personnel to temporarily occupy non-critical sensitive positions pending completion of the National Agency Check (NAC).

4.8.1 If at any time the NAC receives unfavorable adjudication or information that would result in an unfavorable NAC become known, the Contractor shall immediately remove the employee from the non-critical sensitive position.

4.9 The MTF Security Manager shall maintain security files on all Contractor personnel.

4.9.1 The Contractor shall report possible adverse information on contract employees occupying non-critical sensitive positions through the ACOR to the MTF Security Manager.

4.9.2 The MTF Security Manager shall process this information in accordance with standard operating procedures and shall inform the Contractor of all security decisions.

Figure 2-20-N-5 Data Flow Charts

A. TRICARE Senior Option - Enrollment Data Flow

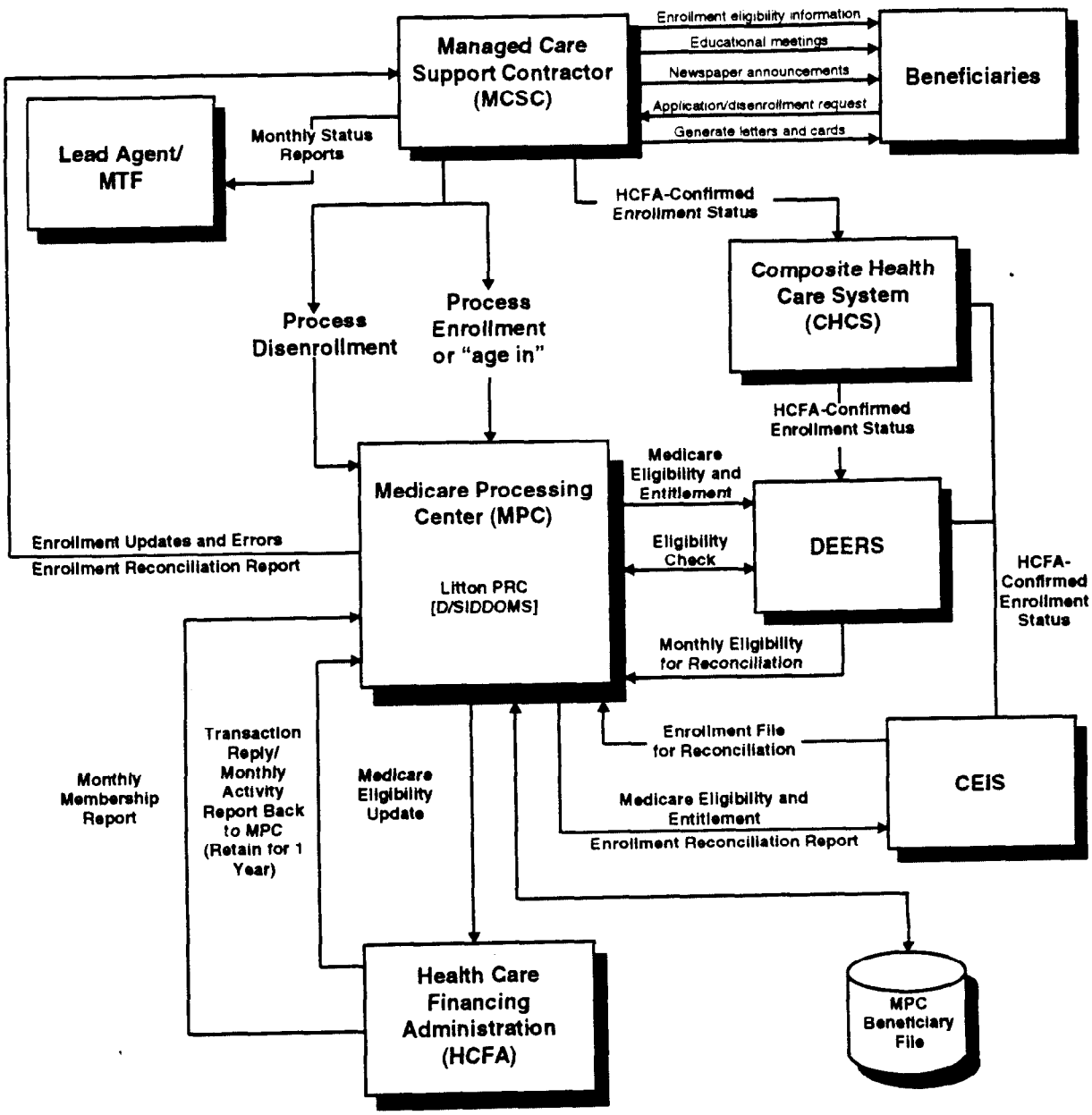

Figure 2-20-N-5 Data Flow Charts (Continued)

B. TRICARE Senior Option - Claims/Clinical Data Flow

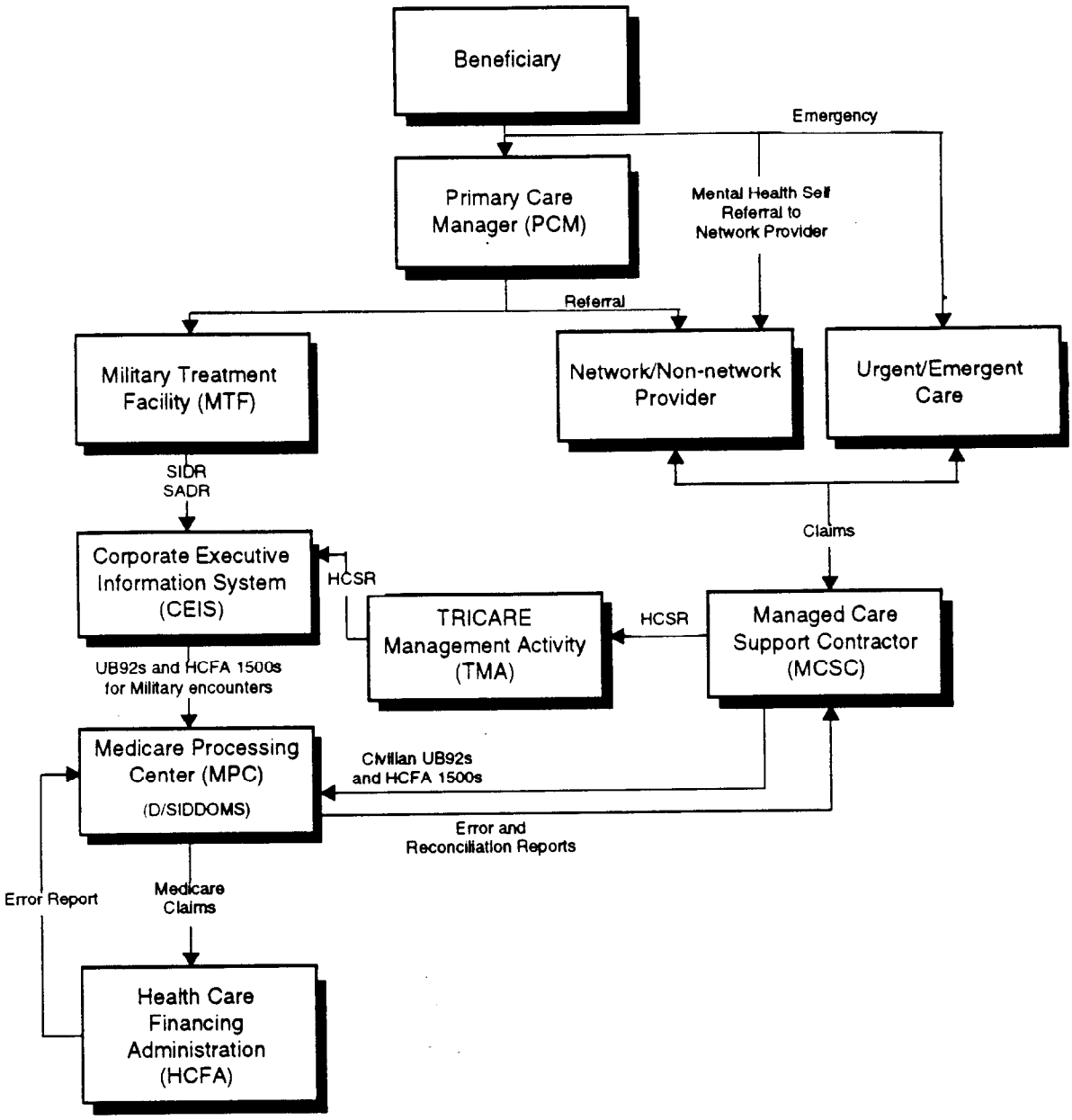

Figure 2-20-N-6 Disenrollment

Involuntary Disenrollment

In all cases of involuntary disenrollment, the enrollee has twenty-nine (29) days from the date of receipt to respond to the Notice of Intent to be Involuntarily Disenrolled. Medicare permits involuntary disenrollment of an enrollee in a Medicare at-risk health maintenance organization following appropriate due process. Under the TRICARE Senior Prime program, the MTF Commander may apply the Medicare procedures for involuntary disenrollment. The MTF Commander may not propose to terminate an enrollee based upon his/her utilization of services or mental illness unless it has a direct effect upon the ability to deliver services. The MTF Commander may not initiate disenrollment because the beneficiary exercises his/her option to make treatment decisions with which the MTF disagrees; e.g., refuses aggressive treatment for cancer.

A beneficiary may be involuntarily disenrolled for the following reasons:

1. Enrollee moves out of the HMO's geographic area. Upon direction of the MTF Commander/Lead Agent, the HMO will disenroll a Medicare enrollee who moves out of its geographic area and does not voluntarily disenroll if the HMO establishes, on the basis of a written statement from the enrollee or other evidence acceptable to HCFA, that the enrollee has permanently moved out of its geographic area. Upon approval of the MTF Commander, the contractor must give the beneficiary a written notice of termination of enrollment. The notice must be mailed to the enrollee prior to the submission of the disenrollment notice to HCFA. The notice to the beneficiary must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established under HCFA regulations 42 CFR §417.436.

2. Enrollee commits fraud or permits abuse of HMO enrollment card. A Medicare beneficiary may be disenrolled by the HMO if the beneficiary knowingly provides, on the application form, fraudulent information upon which an HMO relies and which materially affects his or her eligibility to enroll in the HMO, or if the beneficiary intentionally permits others to use his or her enrollment card to receive services from the HMO. In either case, the HMO must give the beneficiary a written notice of termination of enrollment. The notice must be mailed to the enrollee prior to the submission of the disenrollment notice to HCFA. The notice must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established under HCFA regulations 42 CFR §417.436.

3. Enrollee's entitlement to benefits under the supplementary medical insurance program ends. HCFA's liability for monthly capitation payments to the HMO on behalf of the beneficiary ends with the month immediately following the last month of entitlement to benefits under Part B of Medicare.

(a) If an enrollee loses entitlement to benefits under Part A of Medicare but remains entitled to benefits under Part B, the enrollee automatically continues as a Medicare enrollee of the HMO and is entitled to receive and have payment made for Part B services beginning with the month immediately following the last month of his or her entitlement of Part A benefits.

Figure 2-20-N-6 Disenrollment (Continued)

4. Disenrollment for cause. An HMO may disenroll a Medicare enrollee for cause if the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing enrollment in the HMO seriously impairs the HMO's ability to furnish services to either the particular enrollee or other enrollees.

(a) Effort to resolve the problem. The HMO must make a serious effort to resolve the problem presented by the enrollee, including the use (or attempted use) of internal grievance procedures.

(b) Consideration of extenuating circumstances. The HMO must ascertain that the enrollee's behavior is not related to the use of medical services or

(c) Documentation. The HMO must document the problems, efforts, and medical conditions as described in this section.

(d) HCFA decides based on a review of the documentation submitted by the HMO, whether disenrollment requirements have been met. HCFA makes this decision within 29 working days of receipt of the documentation material, and notifies the HMO within 5 working days after making its decision.

(e) Effective date of disenrollment. If HCFA permits an HMO to disenroll an enrollee for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the HMO complies with the notice requirements.

Before beginning the disenrollment for cause process, the MTF Commander will make a serious effort to resolve the problem presented by the enrollee and inform the enrollee that his/her continued behavior may result in termination of membership in TRICARE Senior Prime. If the problem cannot be resolved, the MTF Commander will give the member written notice of intent to request disenrollment for cause. In this notice, the MTF Commander will include an explanation of the enrollee's rights to a hearing under the organization's grievance procedures.

Proposed Disenrollment Notice

Once the grievance process has been completed or the member has chosen not to use this process, the MTF Commander will provide documentation to HCFA for involuntary disenrollment of the enrollee. Documentation will include:

(1) The reason that the MTF is requesting disenrollment for cause.

(2) A summary of efforts to explain the issues to the enrollee and the other types of options presented before disenrollment was considered.

(3) A description of the enrollee's age, diagnosis, mental status, functional status, and social support system; and

(4) Separate statements from primary providers describing their experience with the enrollee.

Figure 2-20-N-6 Disenrollment (Continued)

Voluntary Disenrollment

A Medicare enrollee may disenroll at any time by giving the HMO a signed, dated request in the form and manner prescribed by the HMO. The enrollee may request a certain disenrollment date but it may be no earlier than the first day of the month following the month in which the HMO receives the request. The HMO must submit a disenrollment notice to HCFA promptly.

An HMO must provide the enrollee with a copy of the written request for disenrollment. Risk HMOs must also provide a written statement explaining that the enrollee remains enrolled in the HMO until the effective date of the disenrollment.

Figure 2-20-N-7 Manual Manipulation of the Spine - Medicare Coverage

Operational Policy Question:

Which practitioners are authorized by law to perform manual manipulation of the spine as a Medicare covered service?

Answer:

Section 1861(r) of the Social Security Act provides the definition of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation demonstrated by x-ray. The statute specifically references manual manipulation of the spine to correct a subluxation demonstrated by x-ray as a physician service. Thus, managed care plans may use physicians to perform this service.

Managed care plans contracting with Medicare are not required, however, to offer services of chiropractors, but may use other physicians to perform this service. In addition, managed care plans may offer manual manipulation of the spine as performed by non-physician practitioners, such as physical therapists, if allowed under applicable state law.

Please also note that section 2153.1 of the Medicare HMO/CMP manual states that marketing materials of managed care plans must clearly state which physician specialties are authorized by the plan to provide manual manipulation of the spine.

Figure 2-20-N-8 HMO 2104. Emergency Services

Assure that medically necessary emergency care is available 24 hours a day, 7 days a week. Beneficiaries are not required to receive emergency services at your plan facilities nor are they required to secure prior approval for emergency services provided inside or outside your geographic area. Provide a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan. (See 2107 for the permissible limits on the amount you must pay.)

2104.1 Definition.--Use the definition provided in 42 CFR 417.401. Specifically, "emergency services" mean covered inpatient and outpatient services that are:

- Furnished by an appropriate source other than the organization;
- Needed immediately because of an injury or sudden illness; and
- Needed because the time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health. Such services must be, or appear to be, needed immediately.

EXAMPLE: While visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacky cough, and generalized tired feeling. The son calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.

In this case, the HMO/CMP is required to pay for the physician's services because the enrollee's medical condition appeared to require immediate medical services.

There does not need to be a threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. You may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.

If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then you are not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation. Upon retrospective review, you cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, you are not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treats a skin lesion. You are not responsible for any costs, such as a biopsy, associated with treatment of this unrelated non-emergency care.

Figure 2-20-N-8 HMO 2104. Emergency Services (Continued)

After the emergency, pay the cost of medically necessary follow-up care. (See HMO Manual Section 2105.)

2104.2 Transfers.--If one of your Medicare enrollees receives emergency medical care in a non-plan hospital, you may wish to transfer the patient to your facility (or a facility that you designate) as soon as possible. Pay the transfer costs, such as an ambulance charge, if it is necessary.

Be aware that the transferring hospital is subject to statutory limitations on when, and how, the transfer may be made. Under Section 1876 of the Act, the hospital must first determine whether the patient's condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer

If the patient's condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer. (See Section 1876(c)(2) of the Social Security Act.)

In general terms, an appropriate transfer is one in which:

- The transferring hospital:
  1. Provides medical treatment to minimize the risks to the individual,
  2. Forwards all relevant medical records, and
  3. Uses qualified personnel and transportation equipment for the transfer;
- The receiving facility:
  1. Has available space and qualified personnel, and
  2. Except for specialized facilities that under Section 1876(g) of the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment; and
  3. The transfer meets any other requirements the Secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

Provide assistance with the above requirements to facilitate an appropriate transfer to one of your facilities or a facility that you designate.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the HMO.

Figure 2-20-N-8 HMO 2104. Emergency Services (Continued)

HMO 2105. URGENTLY NEEDED SERVICES

Urgently needed services are Medicare covered services required in order to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or an injury.

Cover these services if:

- The enrollee is temporarily absent from your geographic area, and
- The receipt of health care services cannot be delayed until the enrollee returns to your organization's geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Urgently needed care pertains only to out-of-area care to treat an unforeseen condition. Prior authorization is not needed in seeking urgently needed services. Your marketing materials must clearly describe the concept of urgently needed services as well as include an explanation of the enrollee's rights in these situations.

EXAMPLE: A 72 year old man had a left femoral bypass graft 6 weeks ago. He goes on his previously scheduled vacation to his sister's house who lives out of the service area. While there, he begins to notice left leg numbness that is occurring with greater frequency and intensity and is not totally relieved by his medications. His sister takes him to see her physician.

Pay for the physician's services because the enrollee's medical condition appeared to be such that the provision of medical services could not be delayed until the enrollee returned to your service area.

Services that can be foreseen are not considered urgently needed services, and you are not required to pay for these services without prior authorization. For example, you are not required to pay without prior authorization when a member who needs routine dialysis or oxygen therapy travels outside your service area for a personal emergency or a vacation. Develop a clear policy on your responsibility and the beneficiary's financial responsibility in these situations. Consider making special arrangements with providers outside your service area or clearly discussing any restrictions on out-of-area coverage with Medicare beneficiaries at the time of application.

Marketing materials must clearly describe the limits of your out-of-area coverage. Assume responsibility for urgently needed services without regard to the length of absence from the geographic area, as long as the enrollee maintains membership in your plan. However, if the enrollee is absent for an extended period (beyond 90 consecutive days) and you have not been notified and have not arranged for membership to continue, you may assume that the move is a permanent move and begin procedures to disenroll the beneficiary. If you do not disenroll the beneficiary and you know that he/she is absent for more than 90 consecutive days, then you are liable for all services rendered, including routine care. (See HMO Manual Section 2001ff.)

Cover medically necessary follow-up care to emergency and urgent care situations if that care cannot be delayed without adverse medical effects.

Figure 2-20-N-9 HMO Peer Review Organization Relationship

Assumption of Review: The PRO is to notify all HMOs in its service area of its assumption of review. This notice is to be sent within five (5) working days of the later of the effective date of its HMO review contract or the date HCFA notifies the PRO of the participation of a risk MO.

The PRO is to comply with all requirements concerning relationships with HMOs, hospitals and other facilities and providers specified in regulation.

Memorandum of Understanding: Each PRO is to modify or execute written agreements (pertaining to review of risk HMO care) acceptable to HCFA with the Medicare risk HMOs in its area no later than 45 days after the later of its HMO review contract effective date or HCFA notification as specified above. The PRO is to notify its project officer if any HMO fails to sign an MOU within 45 days.

The agreement is to identify appropriate contact persons for all required activities (i.e., certification of the list of users/nonusers, certification of the targeted review data, receiving medical records on a flow basis, etc.) and contain the following:

- The party responsible, i.e., the hospital or HMO, for distributing the "Important Message" to enrollees;
- Notification procedures for when an HMO clinic, or other provider, closes and reopens under a different provider name;
- The HMO giving the PRO copies of all policies, protocols, specific to a potential quality concern or a specific area, lists of covered services, lists of participating providers, and quality assurance plans, and providing copies of updates to these on a quarterly basis;
- The selection of all required samples;
- HMO's responsibility to identify and provide ambulatory and other medical records pertaining to all risk HMO care rendered through the termination date of the HMO contract.
- The PRO's right to request records for additional care outside of the standard review period whenever the PRO review suggests the need to investigate possible quality concerns.
- Timing and location of PRO review;
- Procedures for obtaining records or copies of records for review (e.g., photocopying) and the amount the PRO is to pay for photocopying and mailing records;
- Cooperation by the PRO with the HMO and physicians/providers prior to issuing a final quality of care decision;
- Focused review requirements;
- Requirements for the HMO to provide records, when necessary to the PRO for Super PRO review.